Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	

COMMENTS OF ALASKA COMMUNICATIONS

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Executive Summary

The Commission is required by the Communications Act to ensure that Americans in rural areas have access to telehealth services, including advanced services, that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas.[1] To this end, all telecommunications carriers must provide telecommunications services necessary for the provision of health care services to any public or non-profit health care provider that serves persons who reside in rural areas, at rates that are reasonably comparable to rates charged for similar services in urban areas in the same state, and such carriers are entitled by law to the rural-urban difference for fulfilling that obligation.[2]

Recently, the rural health care ("RHC") program has failed to live up to these obligations. Although the Chairman himself acknowledges that support must be sufficient and predictable for rural carriers "to make the long-term investment decisions that will lead to greater connectivity,"[3] the RHC program has failed on both counts – support has been neither sufficient nor predictable – for funding years ("FYs") 2016 and 2017. The program's FY 2018 appears to be headed toward similar problems unless the Commission takes immediate action. These conditions are unsustainable for healthcare providers in rural areas, as well as carriers attempting to provide advanced services to them. They violate the Commission's statutory mandate, and they detrimentally affect the availability, quality and cost of healthcare services for Americans living in rural areas.

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1 47 U.S.C. §254(b)(3).
2 47 USC §254(h)(1)(A).
3 *TR Daily,* Jan. 10, 2018.

The *Notice* does not adequately address the shortcomings of the current RHC program. The *Notice* does not propose a sufficient budget for the RHC program for future funding years, nor does it provide the support necessary to bridge the rural-urban difference for FYs 2016 and 2017. Some aspects of the *Notice* raise serious concerns for telecommunications service providers attempting to furnish advanced, reliable telehealth services to healthcare providers in rural Alaska. The Notice recognizes to some extent the technological developments and legal changes that in recent years have stimulated demand nationwide for universal broadband capabilities sufficient to meet rapidly advancing telehealth needs. The *Notice,* however, overlooks the significantly greater need for support on a per-location basis in Alaska's rural areas than in the rest of the nation. At a point when Alaska's health care providers are developing innovative strategies to provide more advanced healthcare services than previously were available to their rural constituents, innovations that save both money and lives, it is troubling that universal service funding for rural healthcare should be less certain than it ever has been.

The Commission should embrace the urgency to reform the RHC program so the program is responsive to modern telehealth demands. By law, the Commission must consider the specific requirements of RHC beneficiaries in deciding how much support should be budgeted for rural telehealth capabilities. The Commission must ensure that support is predictable, specific and sufficient to meet those requirements. Healthcare providers should not have to wait longer and longer each year for USAC to determine if their patient-critical infrastructure and service needs will be met.

The *Notice* appropriately considers how supported technology has is being used, and asks that RHC providers purchase only the services they need. But reformed RHC rules also should recognize that the needs of rural communities in places such as Alaska, for whom broadband-

supported health care truly can be life-saving and life-changing, are rapidly evolving. The Commission should take this opportunity to update the RHC support mechanism, and the Telecom Program rules in particular, to meet the modern needs of rural communities. The Commission can ensure that support is being used by healthcare providers in rural areas for access to similar services at reasonably comparable rates to those available in urban areas, and at the same time provide greater transparency and predictability in the decision-making process. The Commission should seek to put in place rules that will allow the support program to change with rural healthcare provider needs, not discourage them from developing more advanced telehealth solutions.

At the same time, the Commission is correct in seeking ways to ensure that a limited budget is efficiently distributed and utilized. This should include reform to the timing and processes of the Universal Service Administrative Company ("USAC") in issuing funding commitments, as well as reform to the rules governing the calculation and distribution of support.

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Alaska Communications[4] hereby comments on the Commission's proposals for reform of the Rural Health Care ("RHC") universal service program.[5]

I. IMPORTANCE OF THE RURAL HEALTH CARE PROGRAM IN ALASKA

Alaska is America's largest state, comprising roughly one-sixth of the nation's total land area, and 99.95% of the state is rural – a greater percentage than any other state in the nation.[6] With a population of just over 710,000 of which about 300,000 (more than one-third) live in Anchorage, the state's single urban area.[7] Alaska boasts *several hundred* small communities that are not reachable by road nor connected to an extended electrical grid. Many communities in Alaska are so small or remote that they have no full-time physician. Most of these communities also lack access to modern, redundant terrestrial broadband transmission infrastructure. In short,

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[4] In these comments, "Alaska Communications" represents the following wholly-owned subsidiaries of Alaska Communications Systems Group, Inc.: ACS of Alaska, LLC, ACS of Anchorage, LLC, ACS of Fairbanks, LLC, ACS of the Northland, LLC, and ACS Internet, LLC., all of whom participate in the provision of services to rural health care providers in Alaska.

[5] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, FCC 17-164 (rel. Dec. 18, 2017) (the "*Notice & Order*"). As used herein, the "*Notice*" refers to the substantive portions of this document that comprise the Notice of Proposed Rulemaking, paragraphs 15 through 106, as well as the Introduction and Background sections, paragraphs 1 through 14; and the "*Order*" refers to the portions, in particular paragraphs 107 through 117, that make up the substantive portions of the Order.

[6] *See* U.S. Census Bureau, https://www.census.gov/geo/reference/ua/urban-rural-2010.html.

[7] *See* U.S. Census Bureau, Quick Facts: Anchorage Municipality, Alaska and Alaska, *available at:* https://www.census.gov/quickfacts/fact/table/anchoragemunicipalityalaska,AK/PST045217.

the need in Alaska for continued universal service support through the RHC program remains great.

To call these communities merely "rural" is to understate the cost and complexity for their residents to obtain high-quality health care services: Because this is Alaska, the distance to the nearest physician often is several hundred miles that only can be travelled by air, and only when possible in light of severe weather conditions that persist for weeks at a time. Because this is Alaska, the needed medical specialist might be available only in one facility in the state, or none at all. Alaska patients often must travel to the Lower 48 states to find knowledgeable, experienced (and reasonably affordable) medical specialists. Because this is Alaska, the nearest health care clinic is likely to be a Tribal health care facility with limited staff and uncertain funding.[8] Because this is Alaska, the patients served by the rural health care provider are as likely as not to qualify as low-income families and individuals.[9] Also because this is Alaska, the rural health clinic is likely to be the only customer in the community that purchases the type of

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[8] *See, e.g.,* Letter from Colleen Meiman, Nat'l Ass'n of Community Health Centers, to FCC Chairman Pai *et al.,* WC Docket No. 02-60, GN Docket No. 16-46 (filed May 22, 2017); Letter from Jaylene Peterson-Nyren, Kenaitze Indian Tribe, to FCC Chairman Pai *et al.,* WC Docket No. 02-60, GN Docket No. 16-46 (filed May 24, 2017). *See generally* Alaska Native Tribal Health Consortium ("ANHTC"), "Telehealth in Alaska," available at: www.anthc.org [last visited on ...]("With partnerships among 28 Alaska Tribal health organizations and more than 200 care delivery sites, the Alaska Tribal Health System has made strides in overcoming its greatest health challenges with the aid of telehealth innovations").

[9] *E.g.,* Letter from Nancy Merriman, Alaska Primary Care Ass'n, to FCC Chairman Pai *et al.*,WC Docket No. 02-60, GN Docket No. 16-46 (filed May 24, 2017); Letter from Victor Joseph, Tanana Chiefs Conference, to FCC Chairman Pai *et al.,* WC Docket No. 02-60, GN Docket No.16-46 (filed May 19, 2017); Letter from LaTesia Guinn, Bethel Family Clinic, to FCC Chairman Pai *et al*., WC Docket No. 02-60, GN Docket No. 16-46 (filed May 1, 2017); Letter from Albert Wall, Peninsula Community Health Services of Alaska, to Senator Murkowski, Senator Sullivan & Congressman Young (dated Nov. 8, 2016, filed in CC Docket No. 02-60 on Jan. 9, 2017) (citing correspondence from Colette Reahl, MD, Kenai Medical); Letter from Bess Clark, Community Connections, to Senator Murkowski, Senator Sullivan & Congressman Young (dated Nov. 29, 2016, filed in CC Docket No. 02-6 on Jan. 9, 2017).

broadband services funded under the RHC program. There rarely is any "similar service" or "commercial customer" found in the area (making rate comparisons a challenge for both health care providers and USAC).

A number of these remote Alaska communities have derived significant benefits from the RHC program. Through telehealth services supported by the program, Alaskan rural healthcare providers have developed the capability to provide emergency services, advanced diagnostics, specialized medical treatments, palliative care and mental health care at levels that previously were not possible. They have reduced the cost of and improved the success rate for, treating patients with chronic illnesses such as diabetes and heart disease. They have developed the capability to comply with new electronic health record regulations under Title IV of the American Recovery and Reinvestment Act.[10] As Commissioner O'Rielly has testified, "In terms of telehealth, what they are able to do with very small dollars in remote parts of [Alaska is] very impressive . . . . Other places using telehealth and telemedicine are really eating up some significant dollars, whereas Alaska has been very efficient and addressed the issue very thoughtfully."[11]

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[10] Pub. L. 111-5, 42 U.S.C. § 1395w-4(o).

[11] *See* U.S. Senate, Committee on Commerce, Science, and Transportation, Hearing: "Oversight of the Federal Communications Commission," Testimony of Commissioner O'Rielly (March 8, 2017) (responding to questions from Senator Dan Sullivan, at time 2:38:28 in the archived video webcast, available at: https://www.commerce.senate.gov/public/index.cfm/hearings?ID=B9D3B299-E3CC-480A-B09B-1DEF0512A57C); *see also* Commissioner Michael O'Rielly, Blog Entry, "Alaska: Lessons Learned," Sept. 5, 2014 ("Alaska is a pioneer when it comes to the adoption and use of communications technology to deliver health care services, especially in the more remote areas where transportation is costly. Alaska's health care providers in these remote areas integrate what I refer to as 'technology triage' to diagnose and treat patients. Instead of traditional in-person doctor-patient visits, community health aides use medical carts ('AFHCAN carts') that utilize the telecom portion of the FCC's Rural Health Care Program to 'store and forward' health information to doctors located many miles away. For more complex cases or situations, such as behavioral services, they can use more bandwidth-intensive video teleconferencing services . . .

Investment in these critical telehealth services in rural Alaska has delivered proven benefits in terms of both patient outcomes and cost savings. As one example, more than 40,000 telehealth cases are handled annually by the Alaska Tribal Health System network of some 240 rural health clinics, saving more than $10 million annually in health care-related travel costs alone, according to the Alaska Native Tribal Health Consortium ("ANTCH"). This does not begin to quantify the savings to Medicare, Medicaid, the Veterans Administration, and other taxpayer-subsidized healthcare programs.[12] Alaska Communications believes that the total healthcare-related savings achieved through telehealth services in Alaska would dwarf the $119 million received under the Telecom Program in the last funding year.

As telemedicine capabilities in rural Alaska have improved, so has the demand for bandwidth. Alaska has particularly benefitted from improvements in the standard of care for remote populations. ANTHC reports that, based on current growth, fully *one-half* of all primary care and specialty care medical "visits" in the rural communities its members serve will be delivered by telemedicine by 2021.

As rural telehealth capabilities expand, naturally, so does demand for RHC support. As the Commission observes, funding commitments in the Telecom Program doubled between 2011 and 2016, and continue to increase.[13] This is not necessarily an indication of a problem with the program but rather proof of its success in meeting growing demands of rural healthcare, at least in Alaska. Not only have the applications of this technology for rural healthcare providers

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By using technology effectively, providers in Alaska are able to diagnose symptoms and problems early, and treat minor ailments locally, thereby minimizing expensive and unnecessary health care services and transportation.") (available at: https://www.fcc.gov/news-events/blog/2014/09/05/alaska-lessons-learned).

[12] The Commission has recognized some of the substantial benefits of the RHC program for residents of rural areas. *Notice* ¶¶2-3.

[13] *Notice* ¶9 & Fig. 1.

greatly increased in recent years, but also the FCC has recognized expanded eligibility, including allowing qualified skilled nursing facilities to apply for support as well as consortia that include diverse members.

Revisiting the RHC program budget and rules, therefore, is long overdue.[14] After the program budget remained unchanged for 20 years, the Commission announced that the RHC program would have insufficient funds to support the qualified rural health care applicants who filed for support between September 1st and November 30, 2016, and ordered a 7.5 percent *pro rata* funding reduction.[15] While this ruling adversely impacted rural health care providers and their broadband service providers throughout the nation, it had a particularly harsh effect in Alaska. First, in Alaska, with rural costs especially high relative to urban costs, even relative to *Alaska* urban costs, RHC providers are especially reliant upon RHC support (98 percent was the average rural discount received in 2016, according to the Commission).[16] Second, the Commission waived its rules to permit Alaska carriers to "voluntarily" reduce their prices to RHC providers to close the gap between available support and the prices to which they agreed;[17]

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14 In 2017, Alaska Communications made a number of proposals to keep the RHC program from exceeding available amounts. *E.g., Broadband-Enabled Health Care Solutions,* GN Docket No. 16-46, *et al.,* Letter from Karen Brinkmann, Counsel to Alaska Communications, to Marlene H. Dortch, FCC Secretary (filed June 9, 2017) (hereinafter "ACS June 9 Letter") (proposing, *inter alia*, taking funds from then-existing reserves to increase available funds for the RHC program's FY 2017); *Actions to Accelerate Adoption and Accessibility of Broadband-Enabled Health Care Solutions and Advanced Technologies,* WC Docket No. 16-46, Comments of Alaska Communications, n. 18 (filed May 24, 2017) (recommending that the Commission reset the budget at $600 million for FY 2017, and automatically adjust it for inflation each year thereafter).

15 *See Rural Health Care Support Mechanism,* WC Docket No. 02-60, Order, 32 FCC Rcd 5463 (2017) ("*Alaska RHC Waiver Order*"), *citing* Universal Service Administrative Co., Rural Health Care Program Funding Information, https://usac.org/rhc/funding-information/default.aspx?pgm=telecom. Automatic reductions in funding year support are governed by section 54.675 of the Commission's rules, 47 C.F.R. §54.675(f).

16 *E.g., Notice* ¶12.

17 *Alaska RHC Waiver Order,* 32 FCC Rcd at 5464.

however, the Commission did nothing to make the serving carriers whole. Telecom carriers who elected to forego collection of the difference, for the benefit of rural Alaska healthcare providers, had no opportunity to recover the lost revenues.[18]

For FY 2017, the Commission offered two "solutions" that regrettably provide little (if any) relief to telecommunications providers attempting to serve rural health care providers. First, the Commission approved a potential expansion of the budget for FY 2017 based on "rollover" amounts from prior funding years that are not committed, but did not reveal what this amount might be.[19] Indeed, seven months into the funding year, USAC has yet to announce any funding commitments, or how much support will be made available in total, leaving applicants entirely uncertain as to their planned FY 2017 telehealth projects. Second, the Commission decided that service providers could "voluntarily" lower their rates for FY 2017 to affected rural health care providers – for the second year in a row in the case of Alaska providers – so the latter would not be harmed in the event of a proration of funding year 2017 support.[20] But support amounts remain unknown as of this writing and, as in 2016, the Commission did nothing to lessen the impact on service providers. These so-called solutions are inadequate to ensure that support is both "predictable" and "sufficient" as required by Section 254(b)(5) of the Communications Act.[21]

Alaska Communications provides RHC-supported services to more than 70 rural unique Alaskan healthcare facilities operated by more than 20 different healthcare providers in the state.

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18 *See Bridging the Digital Divide*, WC Docket No. 17-287 *et al.,* Letter from Karen Brinkmann, Counsel to Alaska Communications, to Marlene H. Dortch, FCC Secretary (filed Nov. 3, 2017).

19 *Order* ¶109.

20 *Order* ¶112.

21 47 U.S.C. §254(b)(5).

Three additional healthcare providers have contracted with Alaska Communications for telehealth services in six additional rural locations, but are waiting until they receive funding commitments from USAC before they will begin service. Other rural healthcare providers took FY 2017 services from Alaska Communications but currently are paying only the urban rate. They hope that ultimately RHC support will cover the urban-rural difference, but at present there is no assurance that funding commitments will be forthcoming in any particular case. Alaska Communications has heard from customers that the uncertainty surrounding the sufficiency of support for two funding years in a row likely will cause more healthcare providers to put telehealth plans for FY 2018 on hold, and even cut back on services they previously used.

The Commission now finds itself on the brink of FY 2018 facing the same problems as in previous years. Applicants for FY 2017, which began July 1, still are waiting to hear whether and how much funding they may expect, and whether a pro-rata cut will be employed in the event USAC approves requests for RHC support in excess of the budget. Alaska rural health-care providers that saw dramatic funding cuts[22] for FY 2016 actually asked service providers such as Alaska Communications to postpone and eventually suspend delivery of services for which they previously contracted.

Rural healthcare providers hope to hear that funding will be awarded for FY 2017, but increasingly they are doubtful that they will see resolution of the funding shortage during this funding year or even in FY 2018. Meanwhile, without the benefit of knowing even whether USAC will grant their funding requests at all, or classify their service contracts as "Evergreen,"

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22 *E.g.,* Letter from Victor Joseph, Tanana Chiefs Conference, to FCC Chairman Pai *et al.,* WC Docket No. 02-60 (filed May 19, 2017) (in FY2016 incurred $387,680.61 in unplanned broadband expense due to *pro rata* cut); ACS June 9 Letter at 3 (Southcentral Foundation took $625,000 cut in support for FY 2016).

rural healthcare providers face the prospect of undertaking another duplicative, burdensome, potentially unnecessary competitive bidding process for FY 2018, adding further to the workload of USAC, service providers, and healthcare providers alike.

In these circumstances, rural healthcare providers in Alaska have little confidence that the RHC program will help them gain access to advanced telecommunications services that are reasonably comparable to those available in urban areas, at reasonably comparable prices, notwithstanding the FCC's statutory mandate.[23] Support under this program today is neither "predictable" nor "sufficient" for Alaska rural healthcare providers to make these life-changing, life-saving purchases.[24] In short, the RHC program is failing to meet the requirements of the Communications Act for Alaska's rural healthcare providers, and the rural Alaska residents they serve.

At the same time, according to the Commission, "an increasing concentration of RHC Program funding among a small number of extremely high-support healthcare providers in the Telecom Program."[25] The Commission notes that Alaska health care providers received approximately one-third of total RHC funding in 2016, including $119 million from the Telecom Program, at an average discount rate of 98 percent (compared to a 91 percent average for the other states).[26] The Commission suggests that these statistics are evidence of a lack of price sensitivity on the part of healthcare providers.[27] Alaska Communications thinks the answer is more nuanced. It is true that, in some areas, healthcare providers have only one service provider,

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23 47 U.S.C. §254(b)(3).
24 47 U.S.C. §§254(b), 254(h)(1)(A).
25 *E.g., Notice* ¶10 (the number of health care providers supported by the Telecom Program declined by 36 percent from 2013 to 2016).
26 *Notice* ¶12.
27 *Id*. ¶13.

and thus see no price competition, but it is wrong to conclude that is the only force at work. The lack of predictability in the program in the current funding year and previous funding year has driven away some rural health care providers who applied for funding in prior years, or caused them to put their broadband plans on hold.[28]

As explained above, Alaska is simply far larger and more difficult to cover than other states, and telehealth costs in rural Alaska simply are higher. Based on 2016 data, healthcare providers in rural Alaska communities, on average, require RHC support that is at least three times greater than the national average funding commitment (on a per-application basis).[29] Compared to other areas of the nation, more communities in Alaska still lack access to advanced infrastructure. Therefore, while the number of applicants overall may be relatively small, the costs they seek to defray are relatively high, and in Alaska many rural healthcare facility locations still lack access to the critical connectivity they need to serve rural residents.

Alaska Communications believes that a large proportion of the RHC program logically *should* be devoted to delivering telehealth services in rural Alaska, and the current distribution of support is reasonable because of the extraordinary costs and needs in the state.[30] Nevertheless,

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[28] Alaska Communications currently provides RHC-supported service to more than 70 unique sites, most of them under the Telecom Program but some under the Healthcare Connect Fund ("HCF") as well. Alaska Communications has contracts to serve six additional sites for customers that await FY 2017 funding commitments from USAC.

[29] Per USAC 2016 funding commitment data for Alaska, the average per-application funding commitment to a community served by multiple middle-mile transport providers was $247,126, and the average commitment to a community served by a single middle-mile transport provider was $320,198. Thus, even without considering the 30% higher funding for communities served by a single middle-mile provider, healthcare providers in communities with access to competitive middle mile facilities still require per-application funding that is three times greater than the nationwide average.

[30] For comparison, Alaska is eleven times the size of Arkansas, but received only about seven times the $17.3 million in RHC support that Arkansas healthcare providers received in Funding Year 2016, based on USAC data.

Alaska Communications agrees with the *Notice* that reform is needed – in fact, updating the Commission's rules and changing the way funding requests are processed are essential reforms for the future of telehealth in rural Alaska. These reforms should address three critical aspects of the rules, as addressed in the comments below:

(i) *Adopting an adequate budget for the RHC program*: The Commission should immediately increase the overall budget to provide sufficient and predictable support, ensure the budget anticipates future demand, and recover USAC's administrative expenses outside the budget (as is done for other universal service programs).

(ii) *Ensuring rural health care providers have access to the services they need at reasonably comparable rates, while controlling costs*: Reimbursable rates should be capped at the lower of available satellite or terrestrial rates for functionally similar services; the Commission's rules should not preclude funding for RHC services using advanced technology or market-based terms and conditions; the Commission should gather and publish more information from bids on RHC contracts, as well as feedback on telehealth services actually provided under those contracts, to encourage the purchase of only those services that are necessary for the healthcare provider's needs, at a rate that is reasonably comparable to the available urban rate; the Commission should retain the current "cost-effectiveness" standard that prioritizes the telehealth requirements of rural healthcare providers; the Commission should import the "lowest corresponding price" rule used in the E-rate program to ensure rural healthcare providers pay no more than other customers purchasing the same services; and the Commission should require USAC to accept bids for telehealth services supported by the service provider's published rates combined, where necessary, with third-party rates (plus a reasonable mark-up).

(iii) *Improving USAC's administration of the program*: Requests must be reviewed on a faster and more predictable schedule; transparency must be increased so rural health care providers and their service providers have access to the same pricing data as USAC; the rules should be revised to reflect the way in which advanced services actually are provided today; and the Commission should examine whether USAC's staffing and administrative resources are sufficient and appropriate for the task of processing RHC applications.

II. SUPPORT FOR INCREASING THE BUDGET OF THE RHC PROGRAM

Unlike other universal service programs, automatically adjusted each year for inflation,[31] the RHC program labors under a 20-year-old budget adopted at the program's inception. The budget is not adequate to provide sufficient and predictable support so that Americans in rural areas have access to telecommunications services, including advanced services, that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas, as required by the Communications Act.[32]

Updating the budget to reflect inflation is a logical first step to right-sizing the RHC program. This is consistent with the Commission's rules for the schools and libraries ("E-Rate") program, which has had a much larger budget from the outset.[33] Accounting for inflation alone, according to the *Notice,* the RHC fund's budget would be $571 million for 2017.[34] In Alaska Communications' view, this figure is understated, as the fund could have grown to as much as

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31 47 C.F.R. §54.423(a) (low-income budget to be adjusted annually for inflation); §54.507(a) (E-rate budget to be adjusted annually for inflation).
32 47 U.S.C. §254(b)(3), (5).
33 47 C.F.R. §54.507(a).
34 *Notice* ¶16.

$600 million by FY 2017 with annual inflation adjustments.[35] Inflation is not the only factor to be considered, however.

The budget also must be increased in light of the legal and technology changes that have taken place in recent years. For example, electronic health record-keeping requirements demand more bandwidth as well as secure connections to data storage facilities. "Cloud" computing, storage and retrieval capability similarly demand greater and more reliable bandwidth. Expanded program eligibility means that support now is available to qualified skilled nursing facilities, to certain types of rural-urban consortia, and for some types of multi-year contracts. The Healthcare Connect Fund increased Internet access funding from 25 percent to 65 percent.

Changes in technology have had the most dramatic impact on demand. New capabilities, permit remote medical consultations and diagnostic examinations in real time, a growing number of medical procedures that can be remotely performed, and remote monitoring of patients using non-invasive technology, to name just a few examples. Much of this technology demands not only high-speed bandwidth but a secure path as well as diverse routing to ensure service reliability.[36] Managed services, with dynamic routing and service level guarantees are the norm for telehealth (unlike, say, the E-rate program, which typically funds only "best efforts" Internet

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[35] Inflation can be calculated a number of different ways. Using the Bureau of Labor Statistics consumer price index ("CPI-U"), $400 million in 1997 dollars adjusted for inflation would be about $598 million in 2016, whereas the Commission appears to have used the gross domestic product price index ("GDP-PI") which excludes price changes in imported goods and services. *See Notice* ¶16. While the GDP-PI may have made sense in 1997, the CPI-U is a more reasonable choice in today's economy, when telecom service providers are purchasing most of their equipment from overseas manufacturers. Over that same time span, for example, the Chinese yuan has appreciated from over ¥8 per U.S. dollar to about ¥6.3 per U.S. dollar today. *See, e.g.,* https://en.wikipedia.org/wiki/List_of_renminbi_exchange_rates. This increase alone would raise the cost of imported telecommunications equipment faster than the GDP-PI would otherwise suggest.

[36] As explained below, MPLS service, though more expensive than some other broadband offerings, is best suited for the very specific demands of telehealth services. *See infra*, pp. 32-33.

access). Very soon, the Internet of Things ("IoT") will require still more high-speed, reliable bandwidth, and medical devices are expected to take advantage of IoT capabilities. These developments, taken together, have significantly altered and expanded the needs of healthcare providers for telehealth capabilities. The budget must be updated to reflect these modern demands.

In light of these developments, a budget of $900 to $999 million would not be unreasonable for the RHC program in FY 2018. This would remain a modest (and the smallest) portion within the overall universal service program, with its total budget of nearly $9 billion for four programs.[37] Still, a budget of this size would be likely to cover the demand for the coming year. In contrast, the current budget (even adjusted for inflation) is expected to be insufficient in the current program year, let alone future years.

Further, the Commission on a regular basis should evaluate whether the budget should be adjusted. Anticipated future growth, or declining demand, changes in telehealth technologies and the needs of health care providers should be evaluated every two years, and the budget adjusted accordingly.

As another necessary reform to the budget for the RHC program, the Commission should order that USAC's administrative expenses be recovered outside the budget (as is done for other universal service programs)[38] rather than taken off the top of program funding. Under the Commission's rules, USAC's administrative expenses associated with the RHC program – upwards of $12 million per year – are deducted from the $400 million program budget, leaving

[37] Universal Service Administrative Company, 2016 Annual Report at 20 (showing $8.8 billion in universal service contributions for 2016).
[38] *See, e.g., Connect America Fund*, WC Docket No. 10-90, Report and Order and Further Notice of Proposed Rulemaking, FCC 11-161, 26 FCC Rcd 17663, ¶ 126 & n.198 (2011).

less than $388 million for program support each year. In funding year 2016, this became a problem for the first time, due to demand exceeding available funds, and in 2017 it is expected once again to contribute to a program funding shortfall. Putting aside whether the amount designated for USAC overhead is appropriate, that amount should be recovered over and above the amount budgeted for program support, whether $400 million or $999 million.

III. ENSURING ACCESS TO NEEDED SERVICES AT REASONABLY COMPARABLE RATES, AND REINING IN EXCESSIVE RATES

The *Notice* states that almost one-third of total RHC support went to RHC providers in Alaska in FY 2016, and that the reimbursement percentage or "discount rate" among Alaska carriers (on average 98 percent) exceeds that of other states in the nation (on average 91 percent).[39] The *Notice* states that the average amount of support that health care providers are receiving in both the Healthcare Connect Program and the Telecom Program is increasing,[40] but the Telecom Program support has become more concentrated among a smaller percentage of providers,[41] even as the providers are contributing a smaller percentage of their own resources toward the total cost of services under the Telecom Program.[42] The Commission concludes that RHC providers lack sensitivity to prices for the services the RHC program supports.[43] However,

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39 *Notice* ¶12.

40 *Notice* ¶8 & Fig. 1.

41 *See Notice* ¶10 ("Between FY 2013 and FY 2016, the number of healthcare providers in the Telecom Program declined by more than 36 percent, but the amount of funding dollars committed during this period increased by 67.2 percent. On a per healthcare provider basis, Telecom Program commitments grew from an average of $32,000 in FY 2013 to $81,000 in FY 2016, an increase of 153 percent in just three years. In FY 2016, 5 percent of the healthcare providers in the Telecom Program received 52 percent, or $108 million, of the un-prorated Telecom Program support commitments").

42 Notice ¶9 ("As total commitments from the Telecom Program increased, however, the healthcare provider's out-of-pocket expenses decreased, from approximately $40 million in FY 2011 to approximately $11 million in FY 2016").

43 *Id.* ¶13.

Alaska Communications believes that the circumstances in Alaska are more complex. At least three different aspects of the RHC program must be addressed: (a) the Commission should not permit USAC to subsidize prices for terrestrial services that exceed prices for available and comparable satellite capacity for the same route; (b) the Commission should gather and publish more information about bids on RHC contracts as well as telehealth services actually delivered using supported services; and (c) the Commission should amend its rules so that support is both sufficient under local conditions and targeted where it is most needed.

A. USAC Should Not Subsidize Unreasonable Prices

Many remote communities in Alaska are served by local telecom providers that lack connections between those communities and the rest of the state and the nation (including the Internet). That under-served "middle mile" connection between the local exchange network serving the village or borough and the wider world has long been identified as a bottleneck inhibiting greater broadband availability in remote Alaskan communities.[44] Numerous parties have raised the problem of the cost of bridging the middle mile gap, as well as the pricing differential between terrestrial and satellite-based middle-mile transport capacity in Alaska. Not only does the lack of robust and affordable middle-mile capacity inhibit broadband deployment by incumbent service providers, but also it effectively deters competitive market entry. Where new broadband is deployed, customers, including rural health care providers and (indirectly) USAC, often pay rates that are facially unreasonable – most obviously, where the price of

[44] *E.g., Connect America Fund*, WC Docket No. 10-90 *et al*., Report and Order and Further Notice of Proposed Rulemaking, 31 FCC Rcd 10139, ¶24 (2016) (exempting "Alaska Plan" participating carriers from certain Connect America Fund broadband performance standards where middle-mile is limited to satellite service), citing *USF/ICC Transformation Order*, 26 FCC Rcd 17663, 17699 (2011).

modern terrestrial broadband service exceeds the price of older, less efficient satellite technology on the same route.[45]

One way the Commission can immediately lower the amount of support dispensed in Alaska would be to exercise better oversight of the rates charged for middle-mile capability. Alaska Communications previously has pointed out that the Commission's rules permit service providers to overcharge for terrestrial middle-mile services. As described in the *Notice*, reimbursement of RHC costs for satellite service is permitted even if a functionally equivalent terrestrial service is available, provided the reimbursable rate for satellite service is capped at the terrestrial rate.[46] There is no similar cap on terrestrial service rates, however. This has created a loophole, enabling reimbursement from USAC for rates on terrestrial middle-mile networks in remote parts of Alaska *that exceed even the rates for older, less efficient satellite capacity*. Section 54.609(d) should be modified so reimbursement for either technology is capped at the *lower of the satellite rate or the terrestrial rate*, if functionally equivalent services are available.

Alaska Communications conservatively estimates that charges to USAC for terrestrial middle-mile capacity in some parts of Alaska make up as much as 99 percent of the cost of a broadband circuit to a rural health care provider, at rates that are approximately 25 percent higher than middle-mile rates on other rural routes in the state. Capping the middle-mile rate at the

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45 *E.g., Connect America Fund,* WC Docket No. 10-90 *et al*., Letter from Karen Brinkmann to Marlene H. Dortch, FCC Secretary (filed April 29, 2016) (documenting microwave-based middle mile capacity serving rural Alaska priced at several multiples of the satellite price); *Connect America Fund,* WC Docket No. 10-90 *et al*., Letter from Karen Brinkmann to Marlene H. Dortch, FCC Secretary (filed March 11, 2016) (same, and noting the difference between prices and costs for such capacity); *Connect America Fund,* WC Docket No. 10-90 *et al*., Letter from Karen Brinkmann to Marlene H. Dortch, FCC Secretary (filed November 19, 2015) (same, and including a comprehensive plan for extending broadband to all unserved areas of Alaska via affordable middle mile).

46 *Notice* ¶65, citing 47 C.F.R. §54.609(d).

lower of the satellite or the terrestrial rate, as proposed, could save an estimated $15 million per year -- $60 million over funding years 2013 through 2016. Ironically, these savings would have been more than sufficient savings to avoid the *pro rata* cuts that were so harmful to service providers participating in the 2016 funding year could have been avoided.

The Commission should adopt this rule change immediately, effective in funding year 2017, to avoid any further unnecessary waste on overpriced middle-mile capacity, and any unintended harm to rural healthcare providers or their patients.

B. Disseminating More Information Will Stimulate Competition and Lead to Lower Prices

The *Notice* asks whether a rural health care provider should be required to choose not just a cost-effective solution but the *most* cost-effective solution for RHC-funded projects, in both the Telecom Program and the Healthcare Connect Fund.[47] While cost effectiveness certainly is an important goal, there are many instances where only one service provider bids in response to a RHC request for services, and there may be no comparable commercial customers for functionally similar services in that area by which to judge prices.

In section III.C. below, Alaska Communications suggests some rules that will help ensure bids are appropriately evaluated for reasonableness and cost-effectiveness, even in very remote communities with no commercial customers and only a single service provider bidding on a contract. First, however, sufficient information must be made available both to bidders and to the healthcare providers evaluating bids. Alaska Communications therefore supports several suggestions in the *Notice* that will facilitate well-informed decisions by healthcare providers as well as more efficient use of RHC support.

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47 *See Notice* ¶84 & proposed rule section 54.603.

The Commission proposes that applicants for support under the Telecom Program submit to USAC their request for telecom services, their network plan, and their bid evaluation criteria demonstrating how they intend to select a service provider from among competitive bids, and a certification that they will comply with the program rules, at the start of the RHC program application process, with FCC Form 465.[48] Alaska Communications supports this rule, believing it will help not only USAC but also potential service providers understand the health care provider's requirements, and how dissimilar bids will be scored. Greater transparency and accountability also would be aided by requiring health care providers to identify with greater specificity the uses to which the requested service would be put, the specific criteria of the service that the health care provider deems essential, and the criteria that will be judged on a scale.[49] For example, where a health care provider might previously have requested transmission service of 1 Gbps suitable for video-conferencing, patient monitoring, and secure records transmission, under the new rule, the provider might be required to specify:

- current available bandwidth and utilization history,
- desired bandwidth,
- the desired resolution for video-conferencing,
- the number of patients to be monitored simultaneously,
- the volume of files to be transmitted at peak hours,
- the types of equipment intended to be used with the service,
- the level of security needed for transmissions,
- whether cloud access is needed,

48 *Notice* ¶102.
49 *See id.* ¶¶82-84.

- whether managed network services are needed, etc.[50]

To the extent that a provider believes it can satisfy the health care provider's needs with a less expensive technical configuration than requested, the provider should be permitted to explain how its proposal meets the specific needs of the health care provider even though it may propose lesser bandwidth, or some other change from the requested technology.

Alaska Communications does not believe, however, that the statute permits price to be ranked above all other requirements listed in the health care provider's priorities.[51] Under the current rule, "cost-effectiveness" must be evaluated in light of the healthcare provider's needs, including the features of the service, quality and reliability of transmission, and other factors.[52] Alaska Communications believes this rule closely approximates the statute's requirements and should be retained. If and when the healthcare providers furnish more detailed requirements in their requests for service, service providers and USAC alike will be better positioned to ensure they are providing the most cost-effective service the health care provider needs, and not more than the healthcare provider needs.

The Commission also should order USAC to gather and disseminate more pricing data so that healthcare providers and their service providers have more complete market information on

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50 The Commission seeks comment on including a scoring matrix in its Request for Service forms (FCC Forms 461 and 465). *Notice* ¶102. Alaska Communications believes such an addition would help unify RFPs and guide health care providers' decision-making, as well as increase transparency to bidding service providers and USAC.

51 *See* Notice ¶84.

52 47 C.F.R. §54.603(b)(4) ("After selecting a telecommunications carrier, the health care provider shall certify to the Rural Health Care Division that the provider is selecting the most cost-effective method of providing the requested service or services, where the most cost-effective method of providing a service is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services").

which to base their decisions. Alaska Communications supports a requirement that Telecom Program applicants submit all reasonably relevant competitive bid information from both winning and losing bidders, including all bids they received in response to a request for service, their bid evaluation worksheets or matrices, and correspondence with vendors, as necessary for USAC to understand how they selected a particular vendor for a Telecom Program project.[53] Alaska Communications disagrees with extending this requirement to internal meeting notes or minutes, however, as this is likely to greatly increase the burden on healthcare providers without adding much useful information. The requirement should be specific to formal materials such as the bids themselves, correspondence concerning bids or the bidding process, and documentation of how bids were evaluated. If requests for service contain the additional detail discussed above, the competitive bids – both winning and losing – are likely to provide a wealth of additional information about the cost of providing specific capabilities and serving particular needs of rural healthcare providers.

Alaska Communications also supports a requirement that healthcare providers participating in the RHC program report to USAC annually on the telehealth offerings that were made possible, or enhanced, by RHC-supported services.[54] Such information not only will inform USAC what telehealth applications are possible using particular services in specific areas, but also may help to confirm whether the health care provider's network plan was efficiently designed – for example, whether the healthcare provider purchased too much, not enough, or about the right amount of bandwidth. Further, health care providers should be required to conduct this same sort of annual utilization review with their RHC-supported service providers,

53 *See Notice* ¶103.
54 *See Notice* ¶104.

so that the latter can better understand how to meet telehealth needs most cost-effectively. This information can inform possible service modifications for future years as well.

Requiring healthcare providers to provide the information described above will give healthcare providers more "skin in the game" (price sensitivity) as well as make them more informed consumers of RHC-supported services, ordering only those services they need, at the most affordable price.[55] It will inform USAC not only whether a contract is "cost effective" but also whether the RHC-supported services are, in fact, meeting the needs of rural healthcare providers. It will help service providers more carefully tailor their bids on telehealth contracts. And it will improve USAC's ability to promptly and fairly evaluate future funding requests.

C. Targeting Support Will Improve Outcomes and Increase Predictability

The Commission seeks to ensure that services funded under the RHC program meet the telehealth needs of rural healthcare providers at rates that are reasonably comparable to those available in urban areas of the same state, *and* that those services are provided on a "cost effective" basis.[56] The Commission is considering number of rule revisions and additions to eliminate what it sees as incentive for "waste," and to more surgically target the most urgent rural needs. Alaska Communications has witnessed material improvements in the quality and quantity of health care services being delivered in rural Alaska as a result of RHC support in the last two decades. Alaskan providers have creatively and responsibly husbanded scarce resources to achieve extraordinary improvements in rural health care in a relatively short period of time. Certainly, this progress should be permitted to continue and be expanded.

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55 *See Notice* ¶80.

56 *E.g., Notice* ¶¶79-80.

Nevertheless, opportunities for over-charging USAC do exist for some service providers under the existing rules, as discussed above, and there could be greater incentives for health care providers to use only the support they need, purchase only the services they need, and refine their service decisions on a continuing basis. Some of those improvements will be achieved through greater transparency and accountability, as discussed above. In this section, Alaska Communications comments on the various ideas in the Notice concerning the calculation of support, including how best to avoid reimbursement for excessive costs, ensure that support is targeted where it is most needed, and prioritize support when it falls short of demand.

(i) *Controlling Costs in Determining Support.* In the *Notice*, the Commission seeks comment on a variety of changes to its rules to "control costs" in telehealth services to rural health care providers. The Commission appropriately is considering how services are purchased by rural health care providers, as well as how their support is calculated. As the Commission recognizes, attempts to control costs must be balanced against the need to ensure that the necessary funding is not restricted for those healthcare providers whose service costs are legitimately high.[57] The Commission's proposals to require additional support when the effective discounts exceed some determined benchmark have merit and should be strongly considered. However, Alaska Communications also suggests that the Commission explore the establishment of a second, higher benchmark for health care providers in remote Alaska.

The *Notice* suggests that one way to control costs in the Telecom Program would be to make healthcare providers more sensitive to the price of the supported services they order, by requiring healthcare providers to pay from their own resources some greater portion of the purchase price of covered services. By capping the reimbursement rate, and possibly even

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57 *Notice* ¶*41*.

lowering that cap over time, healthcare providers would have more "skin in the game" and be more conservative when purchasing telehealth services, according to the *Notice*.[58] Thus, the Commission seeks comment on whether to cap reimbursement for FY 2019 at 99 percent of the difference between rural and urban rates, and reduce the cap to 98 percent in some future year. The Commission even asks whether this cap could be brought as low as 90 percent over time.[59]

Rural healthcare providers do pay some portion of the cost of telecom services they receive through assistance from the Telecom Program. To begin with, they pay an amount that is equal to the urban rate in the same state for similar services. The reimbursement rate is determined by the difference between rural and urban prices. A higher reimbursement rate does not perforce indicate that rural rates are artificially inflated, or urban rates deflated. Indeed, rural rates in Alaska do reflect distance as well as the lack of high-speed middle-mile transport capability to many rural communities. Therefore, in Alaska, the rural rate is almost always materially higher than the urban rate.

The Commission only may apply a cap on reimbursement within the requirements of the statute. The Act requires that rural healthcare providers have access to the telecommunications services they need at rates that are "reasonably comparable" to the rates charged for "similar" services in the urban areas of the same state.[60] Thus, a cap on the discount is permissible only to the extent that it permits healthcare providers to pay no greater amount for their essential rural telecom services than is "reasonably comparable" to urban rates for similar services in the state. Alaska Communications believes that reimbursement even at 99 percent could in some instances force rural healthcare providers to pay rates that *exceed* "reasonably comparable" ones. This the

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58 *Notice* ¶45.
59 *Id.*
60 47 U.S.C. §254(h)(1)(A). *See also Notice* ¶43.

Communications Act would not permit. For this reason, Alaska Communications believes that a fixed cap on the discount rate would be problematic if it results in healthcare providers paying more than a nominal amount above the urban rate for RHC-supported services.

As an alternative to a fixed cap on reimbursement, the *Notice* asks whether the Commission should "benchmark" the reimbursement rate based on the discounts received by all healthcare providers; any healthcare provider seeking a higher reimbursement rate than, say, the lowest rate among the five percent of healthcare providers receiving the highest discount, would be deemed an "outlier" and subject to some penalty, which could be rejection or "enhanced review" of the RHC application.[61] Alaska Communications does not believe that the statute permits the Commission to reduce the reimbursement to one rural healthcare provider based on the discount received by other healthcare providers. The cost of providing broadband services in rural Alaska is higher than elsewhere in the nation, and in ensuring that the rates paid by each healthcare provider are "reasonably comparable" to the urban rates for "similar" services *in that state,* the Commission's rules, including any rate benchmark, must take into account Alaska's higher prices.

Another impermissible test suggested in the *Notice* would be grouping all healthcare providers by some objective criteria such as size of staff, number of patients served, or capacity of the facility, and decreasing the reimbursement rate to healthcare providers as their service costs increase relative to other healthcare providers in the same tier.[62] The statute does not require healthcare providers to receive support at levels that are reasonably comparable to the levels received by "similar" healthcare providers. It requires that all healthcare providers receive

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61 *Notice* ¶44.
62 *Notice* ¶57.

support that is reasonably sufficient to cover the rural-urban difference. In fact, this makes good sense, because the cost of serving a rural healthcare facility – at least in Alaska – typically is determined by the type of telecom service ordered, the distance of the facility from existing telecom networks, the bandwidth available from such networks, the cost of services from a third-party provider, and other factors specific to telecom service delivery, and rather than the number of staff or patients served at the facility or other attributes of the individual health care facility.

A better approach to ensuring that the Telecom Program does not reimburse for "excessive" costs is to gather and disseminate more information. As described above, knowing more about the specific needs of healthcare providers at the bid stage, and knowing how they actually used the purchased services after they were funded and deployed, will help USAC, service providers *and* healthcare providers work together to ensure that healthcare providers purchase only those telecom services they need to deliver rural health care services.[63]

Further, Alaska Communications supports the proposal in the Notice that USAC establish a national database of all bids – winning and losing bids – that are submitted to all healthcare providers in response to Form 465 each funding year, grouped by state.[64] This will allow both service providers and rural healthcare providers to compare rates for the same telehealth services being offered not only in any individual healthcare provider's particular location (which may lack a commercial customer or competitive services) but also in other rural areas characterized by similar *network* economics (distance from the nearest existing facilities, capacity of those facilities, reliance on third-party inputs, *etc*.). It would be useful to have access to all prices for all comparable services offered to healthcare providers in the state. Healthcare providers and

63 *See supra* section III.B.
64 *Notice* ¶64.

USAC alike – as well as potential service providers – could derive meaningful comparison information from such a database.

Moreover, the RHC program should benefit from the example of the E-rate program and adopt a "lowest corresponding price" rule. This is a very simple, easily administered rule that would ensure that service providers do not submit bids to, or charge, rural healthcare providers a price for supported services above the "lowest corresponding price" unless the Commission finds that the "lowest corresponding price" simply is not compensatory in the case of the supported services.[65] In case of any question whether rural telehealth services were priced "too high," the service provider would bear the risk in case the same services were found to be offered to other customers at lower prices (including "promotional" rates offered for more than 90 days).

Alaska Communications opposes the idea of benchmarking unless the benchmark is set at a level that reflects actual prices in Alaska. Capping rates based on an "average" of rural rates[66] is problematic in many rural locations, because there is only a single rate for a particular offering – that of the bidder itself – and there is no other customer for the types of services ordered by many health care providers in rural locations in Alaska.[67] Alaska Communications also opposes creation of an "enhanced review" process, which would place a great deal of policy discretion in the hands of USAC.

In the *Notice*, the Commission recognizes that many rural locations remain where no commercial customer is purchasing similar services that can be compared to the services

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65 *See* 47 C.F.R. §54.511(b).

66 *Notice* ¶64 (proposing to allow USAC to compare bid rates to an "average" of rural rates, and seeking comment on requiring USAC to substitute the average for the bid rate if the former is lower).

67 Thus, whether the Commission employs the median or mean, in areas served by rural healthcare providers, there typically will be only one or at most two telecom rates to compare. *See Notice* ¶72.

requested by a healthcare provider, and there are no publicly available rates for similar services in such locations.[68] This certainly is true in Alaska. For this reason, adopting a "lowest corresponding price" rule makes more sense than a rule that requires rates from different locations to be compared.[69]

As discussed above, Alaska Communications also urges the Commission to retain Section 54.609(d) of the rules, which provides that rural health care providers may receive support for satellite service even if there is a functionally equivalent terrestrial service in the healthcare provider's rural area, but such support may not exceed the amount that would be available for the relevant terrestrial service.[70] The rule should be expanded so that the converse also is required: rural healthcare providers may receive support for terrestrial service provided the support does not exceed the amount that would be available for a functionally equivalent satellite service.[71] Regardless of other reforms the Commission adopts, this rule should be in place in funding year 2017 so that terrestrial service providers no longer may charge USAC more than the satellite price for similar services, placing some downward pressure on terrestrial prices even in areas so rural there are no other terrestrial service providers for comparison of services rates.

Alaska Communications agrees with the proposal to eliminate the cost-based support justification mechanism in the RHC program.[72] Not only is location-specific cost-justification a

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68 *Notice* ¶¶62-63. As discussed above, in areas where GCI controls the only middle-mile network, which it operates without any price constraints, universal service programs such as RHC and E-Rate do pay excessively to reimburse customers. *See id*. ¶63.

69 *Cf. Notice* ¶64 (proposing that the "rural rate" be the average of all publicly available rates for the same or similar services "in *the* rural area" where the requesting healthcare provider is located) (emphasis added).

70 47 C.F.R. §54.609(d).

71 *Notice* ¶65.

72 *Notice* ¶66.

Herculean exercise where network costs are concerned, but the process of any cost study and USAC review also would take far too long to be meaningful, given the deadlines established for each RHC funding year.

In considering the urban rate, the other half of the urban-rural difference on which Telecom Program support is based, the Commission is concerned that the current rules may create an incentive for rural healthcare providers to identify the lowest urban rate in the state, and so maximize the urban-rural difference.[73] The *Notice* proposes a cumbersome process whereby rural service providers would submit urban and rural rate data to healthcare providers for the latter to file with their funding requests to USAC.[74] Alaska Communications does not think this would lead to consistent use by healthcare providers of a "correct" urban rate in their requests for support. While it might not be unreasonable to ask rural service providers to provide an "average" of publicly available urban rates,[75] a much more efficient solution would be for USAC to develop a definitive "urban rate" for each metropolitan area, updated every two to three years to reflect market changes, which would govern calculation of the rural-urban difference in all requests for RHC funding. USAC should base this rate on both tariffed and non-tariffed prices that service providers have made publicly available (such as on a web site) for a variety of bandwidths and features that commonly are requested by rural healthcare providers.

Alaska Communications supports retaining the current "urban" definition based on population of 50,000 or more.[76] Because competition is almost universally most intense in

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73 *Notice* ¶67. Alaska Communications does not believe this to be a problem in Alaska, where the only true urban area is Anchorage, and competition also is fierce in other population centers such as Juneau and Fairbanks, making urban rates in Alaska easy to verify.

74 *Notice* ¶68.

75 *Notice* ¶69.

76 *Notice* ¶71.

metropolitan areas, USAC would be assured of the reliability of this information published by the local service providers.[77] For the "rural" definition, Alaska Communications proposes simplifying the current definition. Any area not classified as urban should be treated as rural for purposes of the rural-urban price difference, with a distinction only between areas *on* a federal or state road system, and areas *not on* any such road system. For Alaska, as discussed above, the principal driver of the cost of serving non-urban areas is whether or not they are accessible on the state road system. Therefore, this distinction is a rational basis for pricing analysis.

In defining "rural" for purposes of the rural-urban price difference, the Commission would like a "rural area" to contain sufficient telecom service offerings so that a "meaningful average" rural rate can be determined, and USAC would not have to rely on a single provider's rate.[78] To this end, the Commission seeks comment on establishing "tiers of rurality" within the state, and averaging rates from rural areas across the state within each tier.[79]

While, in principle, the concept of averaging rates from areas that share similar cost-of-service characteristics may seem to have merit, the cost characteristics of serving health care providers in rural Alaska are driven not only by whether the customer location is more or less "rural," but also by the type if service ordered, and the service provider's network characteristics, as discussed above, including whether the service provider already has deployed service in the area or must purchase service from a third party.[80] Thus, costs of service can vary greatly, even

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77 *See Notice* ¶69.

78 *Notice* ¶70. As noted above, Alaska telecom providers often serve rural healthcare providers where there is no rate to "average" other than the provider's own rate to the healthcare provider – there being neither other service providers nor other customers purchasing comparable commercial services.

79 *Notice* ¶70.

80 The Commission seeks to compare rates within areas that have similar cost characteristics. *Notice* ¶70.

within the same borough, and Alaska Communications has found that none of the available classifications of "rural" is sufficient to capture these variations.[81]

In Alaska, the cost for third-party inputs can make for wide differences in rates among competing providers, depending on their network configuration, and can make it difficult for telehealth service providers to predict the rate for a supported service. Where the broadband provider must lease tail circuits from an unaffiliated local exchange carrier, for example, the former must incorporate the latter's rates by reference, and has no ability to predict whether and when those rates will change. Most importantly, in locations where the broadband provider has no middle-mile transport capability and must lease from a third-party provider, the price of that capacity is out of the broadband provider's control. The broadband provider may be the best service provider for a telehealth customer, but it has no alternative to paying the price demanded for third-party inputs, adding a reasonable mark-up. Such factors tend to weigh against fixed categorization of particular geographic areas as more rural or less rural. Nevertheless, as noted above, communities connected by the state road system tend to be more easily served than those off the road system.

Moreover, the statute requires that *all* rural healthcare providers have equal access to telehealth services at the urban rate.[82] The law requires the Commission to budget, collect, and commit such funds as are necessary to achieve this statutory command. The focus properly rests on the differential between the urban and rural cost of service, not on the degree of "rurality" of

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[81] As noted above, USAC data confirms that, in Alaska, costs in areas served by a single middle-mile provider are 30 percent higher, on an average per-contract basis, than prices in areas served by competing middle-mile providers. Note 27, *supra*.

[82] Under Section 254, the Commission must ensure that healthcare providers serving *all* rural locations have access to advanced telecommunications services at rates that are "reasonably comparable" to those available for similar services in urban areas of the state. 47 U.S.C. §254(h)(1).

the healthcare facility location. In Alaska, as discussed above, rural rates depend on a host of factors. By design, the statute provides more support where costs of service are higher, and less where they are lower, based on the actual difference between rural and urban rates. The Commission does not have discretion under this statute to ration support based on its view that some healthcare providers are "more rural" than others.

On balance, Alaska Communications recommends retaining the current rural definitions set forth in Section 54.600(b) of the Commission's rules, rather than adopting any of the changes to the rural definition proposed in the *Notice*. To the extent the Commission feels it must make a distinction between different types of non-urban areas, the dividing line that makes the most sense for Alaska is between on-road and off-road rural areas. The Commission should permit service providers to present to the healthcare customer (and USAC) rates for similar services in other rural locations in the state *that have similar network characteristics*, such as access to competitive or non-competitive third-party service inputs or presence on the road system, to best identify similar services *in similar locations.*

Beyond ensuring that rates to rural healthcare providers are reasonably comparable, rural healthcare providers are entitled to receive "similar services" to those available in urban areas of the same state. The Commission's "functionally similar" test is appropriate,[83] but the rules need updating.

In 2003, the Commission established a set of bandwidth tiers based on the speeds of then-prevailing circuit-switched transport services, up to T-3, or 50 Mbps per second.[84] As the *Notice*

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83 *See Notice* ¶73.

84 *Rural Health Care Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration and Further Notice of Proposed Rulemaking, FCC 03-288 18 FCC Rcd 24546, ¶ 34 (2003) ("*2003 RHC Order*").

acknowledges, rural telehealth services have advanced well beyond the tariffed offerings that were typical when the RHC program was established.[85] RHC contracts today are more likely to be based on negotiated contracts than on tariffed terms. Contrary to the assumption implicit in the 2003 tiers, all bandwidth in today's world of packet-switched service options is not fungible. MPLS, fiber rings, and other advanced offerings do not neatly fit into existing guidance for USAC. Multi-Protocol Label Switching ("MPLS"), Metro Ethernet, and Dedicated Internet Access ("DIA") all offer varying levels of service quality and reliability, network and data security, and capabilities, with price variations reflecting these differences, as further discussed below.

Moreover, rural healthcare providers often request services to meet their immediate telecommunications requirements even knowing that within a short period their requirements will expand. Since the cost of providing many advanced services (including both fiber and satellite-based service) is primarily in the initial deployment, it is common for service providers to build "extra" capacity into their networks to anticipate future growth in demand.

For the Commission to create reasonable tiers of functionally similar services, it must look beyond former modes of purchasing telecom services. All bandwidth is not created equal – comparing two service offerings on bandwidth alone is not likely to ensure a comparison of "similar services." Packetization, routing redundancy, network resiliency, security, dynamic route management, and other aspects of the service help to functionally distinguish between different offerings of similar bandwidth from the customer's perspective. Therefore, it is not

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85 *Notice* ¶73.

sufficient to establish bandwidth tiers[86] -- a matrix of different components would be more appropriate.

As an example, in Alaska, service providers offer both Metro Ethernet and Multi-Protocol Label Switching ("MPLS") services to healthcare providers, but MPLS is particularly well-suited to the needs of the healthcare sector. Like Ethernet, MPLS can deliver high-capacity bandwidth such as 100 Mbps or more. Also, like Ethernet, MPLS networks can carry Internet Protocol ("IP") traffic, and a local area network ("LAN") switch or router can be connected to the network. However, MPLS delivers a mechanism whereby virtual circuits can be defined, significantly improving the security of the data traveling over the network. This is particularly important in the delivery of health care services, where privacy and data security are paramount. MPLS allows for both dynamic (fully managed) and static routing options. Most service providers do not offer managed routers with Metro Ethernet service, meaning more expertise is required of the Ethernet customer (or the ability to outsource the service configuration). In addition, MPLS traffic can be assigned to different service levels for purposes of network latency, jitter and packet loss – effectively allowing packet prioritization where it is necessary for particular medical applications – a feature not found in Ethernet networks. The use of fully meshed architecture and IP addresses also help MPLS networks to avoid the "flooding" of packets (and associated network congestion and latency) that are known to occur on Metro Ethernet networks. Given its benefits for the types of applications used by health care providers, MPLS often is *the most cost-effective* option for rural telehealth, even though it may cost more than some other services that offer similar bandwidth.[87] For these reasons, price should not be

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86 *See Notice* ¶¶76-66.

87 *Cf.* 47 C.F.R. §54.603(d)(4) ("the most cost-effective method of providing service is defined as the method that costs the least after consideration of the features, quality of

the top priority in a list of service criteria; rather, for services to be considered functionally similar they must be compared based on *all* the requirements of the healthcare provider.

(ii) *Ensuring Support for Rural Healthcare.* The Commission seeks comment on several ideas for targeting RHC support so that it supports *rural* health care. Alaska Communications strongly supports this objective.

One aspect of rural health care services that urgently requires support, but has heretofore been unavailable, is in the delivery of patient home monitoring services. As recognized in the *Notice*, home monitoring is widely recognized as an effective means to reduce health care costs, improve patient outcomes, and expand options for health care in rural areas.[88] For these reasons, patient home monitoring is a fast-growing tool being employed in rural Alaska where transportation costs are high and health care professionals are in especially short supply.

Under current rules, telecommunications links between health care providers and rural *residences* are not supported, but they should be. Section 254(h)(1)(A) of the Communications Act requires the Commission to ensure that rural health care providers have access to all telecommunications services that are "for the provision of health care services in a State" at rates that are reasonably comparable to those available in urban areas. Unquestionably, telecommunications services used to connect a patient home to a health care provider for monitoring purposes are being used "for the provision of health care services." Furthermore, if an urban healthcare provider were to purchase a telecommunications service to monitor a patient at his or her home in the same urban area, it would pay only the urban rate for those services. Rural healthcare providers, in contrast, will need to purchase services that are both more

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transmission, reliability, and other factors that the health care provider deems relevant to choosing method of providing the required health care service").

88 *See Notice* ¶78.

expensive (based on the higher costs of service in rural areas) and potentially span a greater distance, to the extent that the service includes mileage-based charges, reflecting the greater geographic coverage of rural health care clinics.

Patient home monitoring services also are within the ambit of Section 254(h)(2)(A) of the Act. That statute broadly authorizes the Commission to "enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all . . . health care providers." If the Commission were to proceed under this provision, Alaska Communications believes the Commission should create criteria for subsidizing patient home monitoring services that would result in a subsidy comparable to that available under the Telecom Program, *i.e.*, the difference between the urban and rural rate for such services. With the growing availability of relatively low-cost fixed wireless connections for short distances, this addition should not add materially to the overall budget for the RHC program, but would add significant benefits that lower the overall cost of healthcare services in rural areas.

Similarly, the Telecom Program should cover certain services that are commonly purchased by health care providers in conjunction with telehealth broadband connections. Principal among these is cloud computing, storage and retrieval capability. Access to the "cloud" is critical for rural healthcare providers to draw upon the resources of a range of healthcare specialists without requiring separate connections to each (which could greatly increase their costs).

In addition to targeting support to some types of services, the *Notice* seeks comment on targeting support based on the needs of the population served by the health care provider, rather

than the rural nature of the community alone.[89] Alaska Communications is skeptical that USAC has the necessary expertise and resources to perform such a complex analysis, and in any event, it seems to stray far afield from the Communications Act's mandate to support necessary telecom services for all rural healthcare providers. In assessing the demands of delivering healthcare services in rural areas, it may be interesting to know whether the community's health care facility has fewer or more practitioners, what types of professionals work there (and how many hours), and whether the clinic serves fewer or more Medicaid recipients,[90] it is not clear such considerations are relevant to the Act's requirement to support rural communications services. The statute does not permit the Commission to make distinctions among more or less "deserving" healthcare providers in allocating support. Support is to be made available to *all* providers of healthcare services in rural areas, regardless of such differences, so they have access to similar services to those available in urban areas, at reasonably comparable rates, as necessary to deliver their rural health care services.

(iii) *Prioritizing Support Where Supply Exceeds Demand.* Alaska Communications commends the Commission for considering all aspects of the RHC program. However, if the Commission continues to anticipate that available support will be outstripped by the needs of rural healthcare providers, it may be necessary (on a temporary basis) to prioritize the distribution of support. To that end, Alaska Communications responds to several ideas raised in the *Notice* for prioritizing support where it is insufficient to meet rural healthcare provider demand.

89 *Notice* ¶30.
90 *Notice* ¶¶30-31.

The *Notice* also seeks comment on whether Healthcare Connect Fund or Telecom Program funding requests should receive general priority over the other.[91] Under current rules, where annual support is capped,[92] Alaska Communications agrees with Tribal Organizations In Alaska[93] and others who argue that funding the rural-urban difference for rural healthcare provider access to telecom services must be given priority because it is *mandatory* under the statute.[94] In contrast, supporting healthcare providers' access to advanced telehealth services, and the extension of infrastructure necessary to access those services, under Section 254(h)(2) of the Communications Act (the Commission's legal basis for the Healthcare Connect Fund), is couched in terms of "economic feasibility." While both programs are vital in Alaska, and both should be fully funded by the Commission, to the extent that support falls short of demand, due to the cap selected by the Commission, priority must be given to Telecom Program projects.

The *Notice* also asks whether the rules surrounding support for consortia should be updated to ensure that support is better targeted to reach rural and Tribal healthcare providers.[95] Alaska Communications believes that, in light of the severe constraints of the RHC budget, which no longer is sufficient to meet RHC provider needs, the Commission has an obligation to ensure that none of this support is going to non-rural healthcare providers, whether through consortia or otherwise. Alaska Communications therefore supports requiring that consortia

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91 *Notice* ¶32.

92 47 C.F.R. §54.675(a) ("The aggregate annual cap on federal universal service support for health care providers shall be $400 million per funding year, of which up to $150 million per funding year will be available to support upfront payments and multi-year commitments under the Healthcare Connect Fund").

93 *See Notice* ¶32 & n. 56 (citing letter from Geoff Strommer, WC Docket No. 02-60, filed August 15, 2017).

94 47 U.S.C. §254(h)(1)(A).

95 *Notice* ¶33.

prove that no RHC funding is flowing to non-rural participants.[96] Further, the FCC should eliminate the three-year grace period for consortia to come into compliance with any minimum rurality requirement.[97] Individual healthcare providers are more in need of support than consortia, by definition – they have no network of providers on which to fall back, and lack the negotiating resources that prompted the Commission to include consortia in the Healthcare Connect Fund.[98] Therefore, to the extent that support must be prioritized, individual healthcare providers should receive priority over consortia, and consortia that include any non-rural healthcare providers should be given the lowest priority of all.

IV. ADMINISTRATIVE REFORMS WILL IMPROVE EFFICIENCY OF THE RHC PROGRAM

In considering how to ensure its RHC program makes the most of a limited budget, the Commission must take a hard look at the administrator. USAC's processing of funding requests, especially in the last two funding years, has fallen well behind the cycle of the funding year, effectively constricting much-needed support and throwing rural health care providers into confusion as their services are disrupted or never begun. The filing window for Funding Year 2018 already is open, even though USAC has not issued a single commitment, seven months into Funding Year 2017.

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96 *Cf. Notice* ¶39. The *Notice* proposes to except from this restriction those non-rural healthcare providers with a direct relationship "as service provider" to a rural healthcare provider; however, the RHC program is designated for telehealth services, not for health care services provided by urban healthcare providers. Alaska Communications therefore opposes such an exception.

97 *See Notice* ¶38.

98 *See, e.g., Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, FCC 12-150, 27 FCC Rcd 16678, ¶ 189 (2012) (designing HCF to "create greater incentives for healthcare providers to join together in consortia and thereby obtain the pricing benefits of group purchasing and economies of scale").

This delay and uncertainty are unacceptable for many healthcare providers, especially those small, non-profit entities with no ability to raise additional funds should USAC fail to deliver the expected RHC support for a year that is quickly expiring. Consequently, some rural healthcare providers in Alaska have asked carriers such as Alaska Communications not to deliver services for which they previously contracted, and some have decided not to issue RHC funding requests for Funding Year 2018. The present uncertainty and lack of transparency are effectively shutting down telehealth services in some areas. USAC does not seem to have sufficient guidance from the Commission to evaluate modern project proposals or their pricing structures. It is unclear whether USAC has sufficient resources to handle the increasing number of requests for RHC support or how USAC is marshalling those resources.

Clearly, more transparency is needed into USAC's processes, and processing must be accelerated and made more consistent, so that support can be predictable as well as sufficient. In this section, Alaska Communications recommends changes to the Commission's rules to compel USAC to process requests for support in a timely manner. In addition, the Commission should adopt administrative requirements that will ensure greater transparency and more predictability in the administration of this program.

First, the Commission should establish a reasonable and standardized timeline for processing of RHC funding requests, to which USAC should be required to adhere. The RHC program was designed by the Commission as a year-by-year regime, with a cap on available funding in any funding year, and strict deadlines for filings by healthcare providers.[99] For FY 2017, which began July 1, 2017, USAC opened a filing window that ran from January 1, 2017

[99] *Wireline Competition Bureau Provides a Filing Window Period Schedule for Funding Requests Under the Telecommunications Program and the Healthcare Connect Fund*, Public Notice, WC Docket No. 02-60, DA 16-979, 31 FCC Rcd 9588 (WCB rel. Aug. 26, 2016).

(the first day to file a Form 465) through June 30, 2017 (the last day to file a Form 466 funding request). That process was different from the multiple window approach followed in FY 2016,[100] and the window has been shortened and the dates changed again for FY 2018.

Further, the Commission proposes to adopt an additional requirement that service providers be required to submit all invoices to USAC within 180 days.[101] Alaska Communications has no argument with deadlines for submissions *to* USAC – deadlines are a necessity for most entities, and can aid in more efficient operations. However, no such deadlines currently apply to USAC's processing of RHC applications.

Applications for funding year 2017, all submitted prior to June 30, 2017, for funding that should have begun flowing as of July 1, 2017, *have yet to be acted upon by USAC*. USAC's inaction effectively has denied much-needed support to rural healthcare providers for more than half the last funding year. The filing window for funding year 2018 is open, yet many healthcare providers are still in the dark as to whether their 2017 contracts will be considered Evergreen, or even granted a funding commitment at all. USAC has failed to process the previous year's filings on any schedule that could be deemed timely. Indeed, in failing to compel USAC to act within a reasonable time frame is a violation of Section 254 of the Act.

The Notice seeks comment on whether the current funding year windows meet the business needs of applicants.[102] Alaska Communications respectfully submits that the date by which USAC will approve or deny funding requests is far more critical than the date on which applications are due. The entire process should be fully completed prior to the start of the

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101 Notice ¶95.
102 *Notice* ¶106.

funding year to ensure timely payments to healthcare providers. Even where the final amount of the funding commitment must await determination of a *pro rata* support reduction factor (which it should not if the Commission correctly budgets for future demand), applicants would benefit greatly from timely information on whether or not USAC intends to issue a funding commitment for their service (in whole or in part), and whether the underlying contract is granted Evergreen status. Such information would give healthcare providers and service providers alike greater confidence and certainty surrounding their participation in the RHC program.

The Commission should adopt a schedule requiring timely USAC action on applications that will ensure effective availability of RHC support on a predictable schedule. For example, the following schedule could be mandated for each funding year:

Action	Deadline	Action By	FCC Form (if any)
Requests for Service	November 1	HCP	461 (HCF) 465 (TP)
Funding Requests Submitted	February 1 (maximum of 90 days – may be submitted earlier)	HCP	462 (HCF) 466 (TP)
Initial Decisions	April 1 (no more than 60 days from receipt of funding request, processed on a rolling basis)	USAC	
Appeals Filed	June 1 (but all appeals filed by April 15 are entitled to a decision by June 1 – see below)	HCP	
Appeals Decided	June 1	FCC	
Funding Distribution Starts	July 1	USAC	

Moreover, the Commission should not restrict health care providers from issuing requests for proposals ("RFPs") before the start of the application cycle. In some cases, healthcare providers are aware of their telehealth requirements well in advance of the next funding year. There is no good administrative justification for preventing them from commencing the RFP

process. Allowing healthcare providers to solicit proposals sooner may help ensure their Requests for Service are more detailed and better targeted to meet their telehealth needs, potentially delivering savings to the RHC program.

Second, the Commission should require greater disclosure by USAC. As discussed above, it would be helpful to healthcare providers and service providers alike to have access to a database of all services requested by healthcare providers and the associated price information submitted in both winning and losing bids. USAC currently is the only entity with access to all of the bid information,[103] giving it a wealth of material on which to make comparative evaluations, but withholding a trove of useful information from the market. Making this information available could increase the competitive nature of bids on RHC contracts and lower costs to the program over time.

In 2014, the Commission adopted a similar reform for the E-rate program. Information regarding the specific services and equipment purchased by schools and libraries, as well as their line-item costs, publicly available on USAC's website, has been made available for funding year 2015 and beyond. The Commission found this change would promote the E-rate program's need for pricing transparency.[104] A similar process could readily be implemented in the RHC program, given that the relevant FCC Forms 462 and 466 already alert users on their face: "Information requested by this form will be available for public inspection."

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[103] Pursuant to FCC rule, the healthcare provider is required to submit to USAC "paper copies of the responses or bids received [by the healthcare provider] in response to the requested services" in the competitive bidding process. 47 C.F.R. §54.603(b)(4).

[104] *See Modernizing the E-rate Program for Schools and Libraries*, WC Docket No. 13-184, Report and Order and Further Notice of Proposed Rulemaking, FCC 14-99, 29 FCC Rcd 8870, ¶¶158-66 (2014).

Third, the Commission should revise its rules for the RHC program to give more specific and relevant guidance to USAC. Many of these rules are two decades old. The services purchased with RHC support today have advanced far beyond the types of services contemplated when the rules were written, and they are priced in ways not contemplated by the old rules. It is not surprising that USAC is challenged in applying them to modern telehealth service contracts. For example:

- Section 54.607(a) – "The rural rate shall be the average of the rates actually being charged to commercial customers, other than health care providers, for identical or similar services provided by the telecommunications carrier providing the service in the rural area in which the health care provider is located." In many parts of rural Alaska, this standard is inapposite as there are no commercial customers with identical or similar services. As discussed above, the Commission's rule should be amended to provide options for determining the "rural rate" in the absence of any commercial customers for identical or similar services in the rural area. Most importantly, enacting a "lowest corresponding price" rule would create a backstop so the funding commitment process could proceed even if there are no comparable services being purchased by commercial customers.
- Section 54.607(b) – "[T]he rural rate shall be the average of the tariffed and other publicly available rates." The types of services purchased by rural healthcare providers are not "tariffed" by most service providers. As reflected in the Commission's recent order on Business Data Services, tariffs reflect a prior era of business and undermine the efficiencies available with a market-based approach.

Rather than look to tariffs or other "publicly available rates," the Commission should simply impose an obligation on service providers to offer rural healthcare providers the "lowest corresponding price" as it does under the E-Rate program.[105] Further, in many cases, the telehealth service provider must obtain capacity from third-party service providers to meet the needs to of rural healthcare providers. The rules should be amended so that USAC will accept the documented quote from a third-party provider, subject to appropriate provisions for confidentiality, plus a reasonable mark-up. The last part of this rule, permitting a carrier to submit "a cost-based rate for the provision of the service in the most economically efficient, reasonably available manner," should be deleted. It is unrealistic to expect a carrier bidding on a one-year contract to submit cost studies to establish that its services meet such a standard, as noted above. Building a cost case for a single location is at best a theoretical exercise when most relevant costs are spread across a network; even if such a case could be made, it would not likely be of use in the context of a rolling one-year support program – the schedule simply is too demanding to conclude such a process within the amount of time available for funding commitments. The "lowest corresponding price" rule places the burden on the service provider without delaying the funding commitment process.

- Section 54.609(a) & 54.675(f) – As discussed at some length above, the Commission is required to ensure that support is provided in the amount of the

105 *See supra*, note 66 & accompanying text, citing 47 C.F.R. §54.511(b).

urban-rural difference, not some lesser percentage thereof. The cap set forth in Section 54.675 therefore violates the statute.

- Section 54.609(d) – Support for satellite services is capped at the amount the rural healthcare provider would have received if it purchased a functionally similar terrestrial-based alternative. Conversely, the rule also should cap support for terrestrial services at the amount the rural healthcare provider would have received if it purchased a functionally similar satellite service.

Finally, USAC should be ordered to improve its administrative transparency. Currently, outside parties have an opportunity to review quarterly reports by USAC setting forth estimated demands for support as well as estimated USAC administrative expenses, and any "reserve" funds available from previous funding periods. These reports, which also contain USAC's recommendation as to the next quarter's contribution factor, are due to the FCC at least 60 days before the start of each quarter, yet the frequently are either late or incomplete, and USAC frequently updates them – sometimes multiple times – closer than 60 days to the start of the quarter. Reviewing these reports from one quarter to the next, the basis of USAC's calculations is seldom apparent. For example, although USAC's projections for the third quarter 2017 were due to the Commission by May 1. Nevertheless, USAC dramatically altered its recommendations for funding the third quarter 2017 RHC program between May 23 and June 2, without explanation.[106] Although the rules require FCC approval of USAC's quarterly

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[106] Universal Service Administrative Company, "Federal Universal Service Support Mechanisms Fund Size Projections for Third Quarter 2017" (filed June 2, 2017) ("USAC June 2 Fund Size Projection"), Universal Service Administrative Company, "Federal Universal Service Support Mechanisms Fund Size Projections for Third Quarter 2017" (filed May 23, 2017), available at: http://www.usac.org/about/tools/fcc/filings/2017/q3/USAC%203Q2017%20Federal%20Universal%20Service%20 Mechanism%20Quarterly%20Demand%20Filing.pdf.

budgets,[107] they routinely take effect without FCC action. As a result of this opaque process, the full $100 million for that quarter was taken out of reserves rather than raised through contributions – depleting reserves that otherwise could have made up the RHC program shortfall of roughly $20 million for FY 2016, and potentially even any shortfall for FY 2017.

In recent months, the Commission adopted a waiver permitting USAC (on a one-time basis) to carry forward any prior years' unused and uncommitted RHC funding to make up any FY 2017 shortfall.[108] It is not clear how much this carry-forward amount might be. It is virtually impossible to discern from publicly available USAC documents. The Commission as well as the public should have greater transparency into these funds. Alaska Communications supports the adoption of a rule (similar to the E-Rate rule) permitting carry-forward within the RHC program of any prior funding year's unused funds to meet demand in a future year.[109]

V. CONCLUSION

For the foregoing reasons, comprehensive review of rules for the Rural Health Care program is urgently needed to ensure that all Americans is rural areas have access to the benefits of modern telehealth capabilities. In addition to serving the needs of rural health care providers and their patients, the reforms discussed herein will bring about cost savings to the nation. Moreover, these reforms are necessary to bring the Commission's RHC program into compliance with the Communications Act and sound public policy.

First, and without delay, the Commission must increase the budget for the RHC program so that rural health care providers have access to the services they need in the current funding

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107 47 C.F.R. §54.715(c).

108 *Order* ¶109.

109 *See Notice* ¶ 19. As noted in section III.C. above, available funds should be prioritized so individual healthcare providers first receive available support, and consortia only to the extent that sufficient funding is available. *See Notice* ¶ 20.

year, and so that there will never again be arbitrary cuts in funding for approved projects serving the telehealth needs of rural Americans. Second, the Commission also should immediately modify rule section 54.609(d), capping reimbursable transport pricing at the *lower of* satellite and terrestrial rates, where both are available, to avoid any further unnecessary waste on overpriced middle mile capacity. These two changes should be made effective in funding year 2017, to put the RHC program back on track to meeting the needs of health care providers serving rural residents, while reducing waste in the program.

Respectfully submitted,

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